STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		O1 COM		(X3) DATE SURVEY COMPLETED	
111,1212111	155252		A. BUILDING		12/20/2011
			B. WING STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER				RAME RD	
GOLDEN	LIVING CENTER-	WOODLANDS	NEWBU	JRGH, IN47630	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	·	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
K0000	REGULATORT OR	LISC IDENTIFFING INFORMATION)	TAG	Dia relation (DATE
Koooo					
	A Life Safety Code Recertification		K0000	Preparation and submission	
	and State Licer	isure Survey was		this Plan Of Correction does constitute any admission or	not
	conducted by t	he Indiana State		agreement of any kind by the	
	Department of	Health in		facility of the truth of any	
	accordance wit	th 42 CFR 483.70(a).		conclusion set forth in this allegation. Accordingly, the	
	Survey Date: 1	2/20/11		facility has prepared and sub- this Plan of Correction solely requirement under State and	as a
	Facility Numbe	r: 000155		Federal Law that mandates a	
	Provider Number: 155252			submission of a Plan of	
	AIM Number:			Correction as a condition to participate in Title 18 and 19	
				programs, and to provide the	
	Survevor: Lex	Brashear, Life Safety		possible care to our resident	
	Code Specialist	•		possible.	
	At this Life Saf	ety Code survey,			
	Golden Living	Center-Woodlands			
	was found not	in compliance with			
	Requirements	for Participation in			
	Medicare/Medi	icaid, 42 CFR			
	Subpart 483.70	O(a), Life Safety			
	from Fire and t	the 2000 edition of			
	the National Fi	re Protection			
	Association (NI	FPA) 101, Life Safety			
	Code (LSC), Ch	apter 19, Existing			
	Health Care Occupancies and 410 IAC 16.2.				
	This one story	facility was			
	This one story facility was determined to be of Type V (000)				
	construction a				
	construction at	na was runy			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

V1VJ21

Facility ID:

000155

TITLE

If continuation sheet

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155252	A. BUILDING 01 COMPI		(X3) DATE S COMPLI	ETED	
		100202	B. WING			12/20/20	711
NAME OF PROVIDER OR SUPPLIER				4088 FR	DDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVING CENTER-\	WOODLANDS			RGH, IN47630		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	rE.	COMPLETION DATE
K0025 SS=E	sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity of 120 and had a census of 103 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/22/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following: Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may			TAG			DATE
	protected by fire-raglass panels and stwo separate compeach floor. Dampe penetrations of sm heating, ventilating systems. 19.3.7 19.1.6.4 Based on observinterview, the factors of 8 states of 10 ft 8 states of 1	acility failed to moke barrier walls st a one half hour	K00	025	K025 What corrective activities will be accomplished for the residents found to have been effected by the deficient practice Corrective action to accomplished of contacting Tri St Fire Protection Services to page	en ken ate atch	01/05/2012
	deficient practi				all large breaks in the firewall	s in	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155252		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/20/2011				
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-WOODLANDS			STREET ADDRESS, CITY, STATE, ZIP CODE 4088 FRAME RD NEWBURGH, IN47630				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	Findings included Based on observations of the facing birector of Maismoke barrier was smoke barrier of 500 and 600 hinch by six included wall which were this was acknown.	rvation on 15 p.m. during a lity with the ntenance, the wall above the doors between the alls had four, four n holes through the e not fire stopped. owledged by the ntenance at the		the attic with Fireproof Dryw small penetrations will be se with fire barrier seal caulking -How other residents have potential to be affected will identified. No other resident affectedWhat measures be put into place or what systemic changes will be not one ensure that the deficient practice does not recur. Maintenance department/Designee to install attic walls on completion subcontracted job requiring access for any damage to the fire/smoke walls. Any dama will be immediately repaired approved fire barrier productions. How the corrective action be monitored to ensure the deficient practice will not rewhat QA program will be pinto place. Maintenance will report any deficient practice executive director who will refurther monitoring is deemed necessary at that timeSystemic changes will be completed by January 5th 2012.	aled d the be ds will nade pect of any attic e ge with ds will e ecur, ut ll to eport hless		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 01 A. BUILDING 155252 12/20/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4088 FRAME RD **GOLDEN LIVING CENTER-WOODLANDS** NEWBURGH, IN47630 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE One hour fire rated construction (with 3/4 hour K0029 fire-rated doors) or an approved automatic fire SS=E extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 K029 -- What corrective actions K0029 01/06/2012 1. Based on observation and will be accomplished for those interview, the facility failed to residents found to have been ensure 1 of 12 hazardous area effected by the deficient room doors, such as a kitchen practice Lensing Building contacted for review and repair of door, would close and latch into kitchen door and latch. The soiled its door frame. This deficient utility room door was adjusted for practice could affect any of the appropriate closure. --How other 103 residents, as well as staff and residents have the potential to be affected will be identified All visitors while in the dining room. residents affected equally. --What measures will be put into Findings include: place or what systemic changes will be made to Based on observation on ensure that the deficient practice does not recur New 12/20/11 at 11:45 a.m. during a fire door for kitchen ordered on tour of the facility with the 1/5/2012 for replacement. Door is Director of Maintenance, the a special order and will be kitchen door from the dining room installed upon receipt of door. Soiled utility room door was was not provided with a latching readjusted for appropriate device. The only way for the door closure. Maintenance department to stay closed was with a slide or designee will check door latch on the kitchen side of the weekly for proper closure x 4 weeks and then monthly door. This was acknowledged by thereafter. --How the corrective the Director of Maintenance at the action will be monitored to

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AND PLAN OF CORRECTION IDEN		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155252	(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 01	(X3) DATE COMPL 12/20/2	ETED	
NAME O	F PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP CODE					
GOLDEN LIVING CENTER-WOODLANDS					RAME RD IRGH, IN47630			
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
	interview, the ensure 1 of 12 room doors, so Utility room do with a properly closing device deficient pract residents, as wisitors in the Findings include Based on obset 12/20/11 at 1 tour of the fact Maintenance, to Utility room do with a self close however, the completely who times. There was over 50 so and contained barrels at the total three was a cknowledge.	bservation and facility failed to hazardous area uch as a Soiled por, was equipped y operating self on the door. This ice could affect 28 yell as staff and 100 hall. de: rvation on 2:30 p.m. during a ility with Director of the 100 hall Soiled por was provided			ensure the deficient practi- will not recur, what QA program will be put into pl No further corrective action required on the kitchen door new door installed with appropriate latching.Soiled or room door will be checked with x 4 weeks and then monthly thereafter for proper closure Results will be given to Execute director to report in QAA modition x 6 months unless further monitoring is deemed neces at that timeSystemic changes will be completed January 6th 2012.	ace. once utility veekly cutive onthly		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155252		(X2) MULTIPLE CO	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 12/20/2011			
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-WOODLANDS			B. WING T2/20/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 4088 FRAME RD NEWBURGH, IN47630				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
K0050 SS=F	varying conditions shift. The staff is to is aware that drills routine. Responsi conducting drills is competent person exercise leadershic conducted between announcement manualible alarms. Based on recording the provide quarter documentation during 1 of 4 quarter documents in the findings included the provide that the provide the provide that the provide the provide that the p	at unexpected times under, at least quarterly on each familiar with procedures and are part of established bility for planning and assigned only to s who are qualified to p. Where drills are in 9 PM and 6 AM a coded ay be used instead of 19.7.1.2 id review and acility failed to rly fire drill for 1 of 3 shifts uarters. This ce could affect all e facility.	K0050	K050 What corrective act will be accomplished for the residents found to have be effected by the deficient practice Maintenance department to be inserviced timeliness of fire drillsHo other residents have the potential to be affected will identified All residents affeequallyWhat measures who put into place or what systemic changes will be not one of the deficient practice does not recur Maintenance department to 1 fire drill per quarter for all shifts. A different shift to ho drill each month. Executive Director/designee will review building engines program measure the deficient practice will not recombe monitored to ensure the deficient practice	on w I be cted will hold 3 st fire // onthly - will will s		

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		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED 12/20/2011	
		155252	B. WING	G		12/20/2	011
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-WOODLANDS			STREET ADDRESS, CITY, STATE, ZIP CODE 4088 FRAME RD				
GOLDEN	LIVING CENTER-V	WOODLANDS		NEWBU	RGH, IN47630		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCE	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0062 SS=E	Director of Main Administrator a record review. 3.1–19(b) Required automatic continuously main condition and are in periodically. 19. NFPA 25, 9.7.5 1. Based on observation facility were free of consumer 1 of	ed automatic sprinkler systems are lously maintained in reliable operating on and are inspected and tested cally. 19.7.6, 4.6.12, NFPA 13, 25, 9.7.5 don observation and interview, the facility ensure 1 of over 400 sprinkler heads in the vere free of corrosion. NFPA 101 Section fers to NFPA 25, Standard for the Inspection, and Maintenance of Water-Based Fire		0062	what QA program will be put into place. Maintenance Department to report to Executive Director the fire drill inservice held each month with staff which will be reported in QAA x 6 months unless further monitoring is deemed necessary at that timeSystemic changes will be completed by January 13th 2012. K062 What corrective actions will be accomplished for those residents found to have been effected by the deficient practice Tri State Fire Protection contacted for review and repair of the fire sprinkler headsHow other residents have the potential to be affected will be identified All residents affected equallyWhat measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur Tri State Fire Protection replaced the corroded sprinkler head in the		01/05/2012
	replaced that is painted or corroded. This deficient practice could affect mostly staff while in the Service Hall or telephone room. Findings include: Based on observation on 12/20/11 at 11:55 a.m. during a tour of the facility with the Director of Maintenance, the sprinkler head in the telephone room next to the reach-in freezer was covered with corrosion. This was acknowledged by the Director of Maintenance at the time of observation. 3.1-19(b)						
	2. Based on observa failed to ensure 1 of 1 Employee Breakroom obstructions to the sp 9.7.5 refers to NFPA Testing, and Maintena Protection Systems.	tion and interview, the facility sprinkler heads in the bathroom was free of ray pattern. NFPA 101 Section 25, Standard for the Inspection, ance of Water-Based Fire NFPA 25, 2-2.1.2 requires tions to spray patterns shall be			telephone room and relocate sprinkle head in the employe bathroom to the proper distar from the wall. Fire sprinkler h will be monitored for corrosio the maintenance department monthlyHow the correctivaction will be monitored to	e nce leads n by	

Facility ID:

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/13/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING		NSTRUCTION 01	(X3) DATE S COMPL		
		155252	B. WING			12/20/20	011
NAME OF PROVIDER OR SUPPLIER				88 FR	DDRESS, CITY, STATE, ZIP CODE AME RD		
GOLDEN LIVING CENTER-WOODLANDS			I NE	MBO	RGH, IN47630		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI			(X5) COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	'AG DEFICIENCY)			DATE
	Installation of Sprinkle sprinklers shall be loc to discharge. NFPA of 4 inches between the deficient practice counterployee Breakroom. Findings include: Based on observation a tour of the facility when pendant sprinkler Breakroom bathroom which could restrict the discrete sprinkler in the pendant sprinkler breakroom bathroom which could restrict the discrete sprinkler in the pendant sprinkl	n on 12/20/11 at 1:35 p.m. during ith the Director of Maintenance, head in the Employee was within one inch of the wall sprinkler sprinkler head was actuated.			ensure the deficient practice will not recur, what QA program will be put into place. Fire sprinkler heads where monitored for corrosion by maintenance department monand be reported to the Execut Director who will report findin QAA monthly x 6 months unlifter the monitoring is deemed necessary at that timeSystemic changes will be completed by January 5th 2012.	vill the nthly tive gs in	

000155